530 South Jackson Street
Louisville, KY 40202
Telephone 502-562-3000

University Hospital
a proud member of UofL Health Care

DISCHARGE SUMMARY

NAME OF PATIENT: ENGLAND, FANNY 905
MEDICAL RECORD NUMBER: 1153375
ACCOUNT NUMBER: 36718179

ADMISSION: 08/18/2007
DISCHARGE: 08/25/2007

SERVICE: ORTHOPEDIC SURGERY
ATTENDING PHYSICIAN: MADHUSUDHAN YAKKANTI, MD

PRINCIPAL FINAL DIAGNOSIS:
1. Open right tibia fracture.
2. Open right tibial pilon fracture.

PROCEDURES:
1. Irrigation and debridement, external fixator application to right tibia fracture and right pilon fracture. Please see full dictated operative note for details of this procedure performed on 08/18/07.
2. Split-thickness skin graft to right lower extremity performed on 08/23/07 by Plastic Surgery Service.

CONSULTATIONS:
1. Trauma Surgery.
2. Plastic and Reconstructive Surgery.
3. Spine Surgery.
4. Internal Medicine.
5. Physical Therapy.
6. Social Service.

HISTORY OF PRESENT ILLNESS: The patient is a 47-year-old lady who was in a car accident as the restrained driver with prolonged extrication. She sustained a right lower extremity tibia and pilon fracture, which was open. She was seen and evaluated in the Emergency Room and admitted initially by the Trauma Surgery Service. >

HOSPITAL COURSE: She was taken by the Orthopedic Surgery Service to the operating room on the first post-injury day. She was irrigated and debrided and an external fixator was placed. Antibiotic beads were placed. The beads were pulled and Plastic Surgery consult was obtained. The wound was covered by the plastic surgeons on 08/24/07.

EXHIBIT B

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DISCHARGE SUMMARY

NAME OF PATIENT: ENGLAND, FANNY
MEDICAL RECORD NUMBER: 1153375

She was stable throughout her hospital course without any signs or symptoms of DVT, PE or infection. She was cleared by the Trauma Surgery Service of any other injuries including head, neck, abdomen, chest and pelvis. Her hospital course was unremarkable. Prior to discharge she was walking, tolerating p.o. She was without any other signs of injury. She was given the following instructions.

DISPOSITION: Home. >

DISCHARGE MEDICATIONS:
1. Lovenox 40 mg once daily to decrease the risk of blood clots.
2. Keflex 500 mg q.i.d. as antibiotic.

DIET: >

ACTIVITY: > She is to be non-weightbearing on the right lower extremity. She is to keep the leg elevated. She should perform pin care b.i.d.

FOLLOW-UP: > She should follow up with Plastic Surgery in 1 week in the ACB on the second floor. She should call for an appointment. She should follow up with Orthopedic Clinic with Dr. Yakkanti on 08/30/07 at 562-6501, ACB first floor. She should call for an appointment. She should call the doctor for any temperature over 101, excessive vomiting or diarrhea, redness, swelling or drainage from incision, incision pulling apart or any other concerns. She should call 562-6501 or 911 with any questions or concerns.

Electronically signed on 09/10/2007 4:58PM

David Chen, M.D.

FOR

Electronically cosigned on 09/12/2007 10:52PM

Madhusudhan Yakkanti, M.D.

DC/mt
DD: 08/25/2007 @ 19:52

530 South Jackson Street
Louisville, KY 40202
Telephone 502-562-3000

University Hospital
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EMERGENCY ROOM NOTE

NAME OF PATIENT: ENGLAND, FANNY 905
MEDICAL RECORD NUMBER: 1153375
ACCOUNT NUMBER: 36718179

DATE: 08/17/2007

ATTENDING PHYSICIAN: Melissa Platt, M.D. (present and available throughout the room 9 resuscitation)

HISTORY OF PRESENT ILLNESS: The patient is a 57-year-old Caucasian female who presents status post a one-car motor vehicle accident in which she was the restrained driver. She had no loss of consciousness. She had entrapment of her right lower extremity with a prolonged extrication time of greater than one hour. She presented complaining of pain to her right lower extremity and her back.

PAST MEDICAL HISTORY: Significant for hypertension and diabetes. She had an unknown back surgery prior.

ALLERGIES: She has no known drug allergies.

MEDICATIONS: She does not remember her medications. She takes medications for blood pressure and diabetes.

FAMILY HISTORY: No related family history.

SOCIAL HISTORY: Denies smoking, drinking or drug use. Last tetanus was unknown.

PHYSICAL EXAMINATION:

VITAL SIGNS: Her temperature was 98.7 degrees Fahrenheit, heart rate 105, respiratory rate 28, blood pressure 194/119 and oxygen saturations were 96% on 4 liters nasal cannula.

GENERAL: She was uncomfortable, well developed and well nourished with a Glasgow Coma Scale of 15.

EYES: Her pupils were 3 millimeters equal, round and reactive bilaterally.

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EMERGENCY ROOM NOTE

NAME OF PATIENT: ENGLAND, FANNY
MEDICAL RECORD NUMBER: 1153375

ENT: She had a left tympanic membrane perforation that she reported old, associated with deafness in that ear. She had no nasoseptal hematoma, no malocclusion.

NECK: In a cervical collar with no obvious injuries, no spinous process tenderness.

LUNGS: She has a normal respiratory effort. Her lungs are clear to auscultation bilaterally. She has tenderness to palpation over her right chest wall with ecchymosis of her right chest wall.

HEART: Tachycardic and regular with intact radial and pedal pulses.

ABDOMEN: Soft, non-tender and non-distended, normoactive bowel sounds. Has normal rectal tone and no gross blood. She

GU: She has normal female external genitalia.

EXTREMITIES: Her right lower extremity has an open tibia/fibula fracture. She moves her toes up and down.

BACK: No spinous stepoffs. No spinous tenderness to palpation.

PELVIS: Stable.

SKIN: She has ecchymosis to her right chest wall. She has an open tibia/fibula fracture of her right lower extremity and she has an abrasion to her left knee.

NEUROLOGICAL: Cranial nerves intact. Her sensory motor exam is otherwise intact. She was alert and oriented times three.

ROOM 9 INTERVENTIONS: The patient was brought to room 9 by ground Emergency Medical Services. She was connected to oxygen via nasal cannula and connected to cardiac, blood pressure and pulse oximetry monitor. Her airway was self maintained. Her breathing was spontaneously with equal breath sounds and chest rise bilaterally. Her circulation, sinus rhythm on all monitors, two peripheral IV's. She presented with a Glasgow Coma Scale of 15. She was transferred to room 9 bed in a cervical collar and a backboard. Prior to arrival, she received 100 milligrams of Fentanyl. In room 9, blood was drawn and laboratories were sent. X-rays were done including a chest, pelvis and right tibia/fibula. Chest x-ray showed increased pulmonary markings on the right versus the left, no fractures and no pneumoperitoneum. The pelvis x-ray showed no acute fractures. The tibia/fibula x-ray showed a right mid shaft tibia right fibular fracture and a

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EMERGENCY ROOM NOTE

NAME OF PATIENT: ENGLAND, FANNY
MEDICAL RECORD NUMBER: 1153375

right pilon. FAST scan performed by Dr. Herold was negative in all four quadrants. The patient was log rolled off the board. A Foley catheter was placed. The patient's history and plan will be discussed with family in their presence. Consult orthopedic surgery.

IMPRESSION:
1. Right tibia/fibula fracture, both open fractures.
2. right pilon fracture
3. Seat belt sign.

DISPOSITION: CAT scan for MAN scan of T and L recons and on to emergency department, bed #16 with disposition determined later.

CRITICAL CARE TIME: 15 minutes.

Addendum: The patient's right tibia/fibula fracture, orthopedic surgery was present in room 9 and the patient's open fracture was irrigated with approximately 2 liters of normal saline and splinted in a long posterior leg splint with stirrups. The patient received a tetanus. The patient was received Kefzol and tobramycin in room 9 for pain control, the patient received ____ 1 milligrams, Fentanyl 200 milligrams and she received Versed 2 milligrams for an attempted reduction of the right tibia/fibula by orthopedic surgery which was unsuccessful in room 9.

Electronically signed on 09/05/2007 12:09PM

Katherine Susanne Herold, M.D.

KSH/jw
DD: 08/17/2007 @ 18:50
DT: 08/19/2007 @ 11:09
EDIT: 08/19/2007 @ 11:09
JOB #: 501842

530 South Jackson Street
Louisville, KY 40202
Telephone 502-562-3000

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OPERATIVE SUMMARY

NAME OF PATIENT: ENGLAND, FANNY 905
MEDICAL RECORD NUMBER: 1153375
ACCOUNT NUMBER: 36718179

DATE OF SURGERY: 08/18/2007

SERVICE: Orthopedic Surgery

PREOPERATIVE DIAGNOSES:
1. Grade III-B open fracture of right tibia and fibula
2. Fracture of right tibial pilon

POSTOPERATIVE DIAGNOSES:
1. Grade III-B open fracture of right tibia and fibula
2. Fracture of right tibial pilon

PROCEDURE PERFORMED:
1. Irrigation and debridement of open right tibia and fibula fracture
2. Uniplane external fixator of right leg spanning the ankle
3. Vacuum assisted closure of right leg wound
4. Insertion of non-biodegradable drug delivery system

ATTENDING SURGEON: Madhusudhan Yakkanti, M.D.
FELLOW/RESIDENT SURGEON: Matthew Price, M.D.
ASSISTANT(S):

ANESTHESIA: General anesthesia.
ESTIMATED BLOOD LOSS: Less than 100 cubic centimeters.
FLUIDS GIVEN: Please see Anesthesia note.
DRAINS: Nil.
SPECIMENS: Nil.
COMPLICATIONS: Nil.
POSTOPERATIVE CONDITION: Stable.

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OPERATIVE SUMMARY

NAME OF PATIENT: ENGLAND, FANNY
MEDICAL RECORD NUMBER: 1153375

INDICATIONS: Ms. England is a 47-year-old female who was admitted with a Grade III-B open fracture of the right tibia and fibula. X-ray examination of her right leg also revealed a right pilon fracture. She was examined in the Emergency Room and was placed into a posterior splint after copious irrigation with saline. She did have exposed bone in the middle third of the leg with large avulsion flaps of the anterior compartment of the leg. The options and alternatives have been discussed in detail with the patient. She elected to proceed with irrigation and debridement and external fixation. The likely risks including but not limited to infection, malunion, non-union, necessity for a Plastic Surgery procedure, and the necessity for multiple surgical procedures have been discussed. Despite the risks involved, she elected to proceed. An informed consent was obtained and she was scheduled for emergency surgery.

FINDINGS:

DESCRIPTION OF PROCEDURE: Ms. England was taken to the University of Louisville Hospital Operating Room. She was transferred to the Operating Room table as a log roll. Her spines were cleared. After achieving adequate general anesthesia, her right lower extremity was irrigated thoroughly with six liters of saline. Following this, the right leg was prepped and draped. A Plastic Surgery consult was obtained intraoperatively.

The right leg had an open wound measuring 20 centimeters x 15 centimeters with a distally-based flap and an irregular laceration of the right leg. There was gross contamination seen. There was exposed bone. Both the proximal and distal fragments of the fracture of the tibial shaft were seen in the wound. There was no evidence of crushed muscle.

Adequate debridement of the subcutaneous fat, devitalized muscle, and contaminated fascia was done. Loose fracture fragments less than 5 millimeter in size were removed. The wound was thoroughly irrigated with bulb syringe followed by Simpulse with six liters of saline.

Following this, a 6 millimeter Tobramycin antibiotic bead chain was placed next to the fracture site. Sutures of 3-0 nylon were utilized to approximate the wound skin edges to a large extent. An area of approximately 3 centimeters x 10 centimeters of length of wound was still uncovered with skin. It was planned that she will be having a VAC device on the right leg wound.

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OPERATIVE SUMMARY

NAME OF PATIENT: ENGLAND, FANNY
MEDICAL RECORD NUMBER: 1153375

Apex pins were placed into the proximal tibial segment, 5 millimeter half pins. Two of them were utilized in the proximal tibia and two 5 millimeter half pins were utilized in the distal tibial segment. A 5 millimeter transcalcaneal pin was placed. The pins were connected to connecting bars. The fracture reduction was checked. The reduction was satisfactory. A VAC device sponge, small size, was obtained and was cut to the size of the wound and was placed over the wound. There was adequate seal obtained with the VAC device.

Ms. England tolerated the procedure well. There were no complications. She had good distal pulses and adequate capillary refill. We will give her antibiotics on the Floor to prevent infection. She may require a repeat I and D if necessary. We will follow-up with Plastics for possible skin coverage and gastrosoleus(?) flap.

Electronically signed on 08/22/2007 7:19PM

Madhusudhan Yakkanti, M.D.

MY/pa
DD: 08/19/2007 @ 19:39
DT: 08/20/2007 @ 14:33
EDIT: 08/20/2007 @ 14:33
JOB #: 502716

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Louisville, KY 40202
Telephone 502-562-3000

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CONSULTATION

NAME OF PATIENT: ENGLAND, FANNY 905
MEDICAL RECORD NUMBER: 1153375
ACCOUNT NUMBER: 36718179

DATE: 08/17/2007

REQUESTING SERVICE:
CONSULTING SERVICE: ORTHOPEDICS – Madhu Yakkanti, M.D.

Please note that history was obtained from patient and chart.

CHIEF COMPLAINT: Motor vehicle accident.

HISTORY OF PRESENT ILLNESS: This is a 57-year-old lady who was involved in a single car motor vehicle accident. Denies loss of consciousness. There was a prolonged extrication. She was the restrained driver. She complains of pain in her right lower extremity, no other musculoskeletal complaints. Denies numbness or tingling. No other complaints. This patient was seen in room 9.

PAST MEDICAL HISTORY: Hypertension and diabetes.

PAST SURGICAL HISTORY: Back surgery.

ALLERGIES: None known.

MEDICATIONS: She takes daily, blood pressure medicines and diabetes medicines, it is unknown what medicines she takes.

FAMILY HISTORY: Noncontributory.

SOCIAL HISTORY: Denies tobacco, alcohol or recreational drugs. Unknown date of last tetanus.

REVIEW OF SYSTEMS: No other complaints except as above.

PHYSICAL EXAMINATION:
VITAL SIGNS: Stable.

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CONSULTATION

NAME OF PATIENT: ENGLAND, FANNY
MEDICAL RECORD NUMBER: 1153375

EXTREMITIES: Bilateral upper extremities, good active range of motion. Skin is intact. Brisk capillary refill, 2+ radial pulse. Can flex and extend fingers and thumbs. AIN, PIN and ulnar nerve, and motor intact. She can feel light touch grossly in the radial, medial and ulnar nerve distribution. Left lower extremity, good active range of motion. Toes and ankles flex and extend. She had brisk capillary refill, 2+ dorsalis pedis pulses. Skin is intact. She has no tenderness to palpation of the left lower extremity. Right lower extremity, splint applied in the field was removed. She has an open tibia fracture grade IIIB. She has stellate wound measuring approximately 14 to 16 centimeters, is stellate. The bone is exposed and the anterior compartment is exposed. This is irrigated with 2 liters of normal saline. As much grass as possible is removed from the wound. At the end of the irrigation, there was no grass visible in the wound, no dirt visible in the wound. She can flex and extend her toes and ankles. She has brisk capillary refill. She has 2+ dorsalis pedis pulses and she can feel light touch grossly in the L4 to S1 distribution. She has tenderness to palpation of the distal lateral femur. She has tenderness to palpable over the distal ankle and proximal foot at the ankle joint. Her skin is as described above. She has a large wound over the anterior and anterolateral tibia, otherwise she has no other fractures and she has no other skin defects noted in the right lower extremity.

DIAGNOSTICS: Her x-rays reviewed show a fracture of the right tibia and right pilon that are displaced. The fracture was attempted to be reduced in the emergency room as the fracture was unstable and unable to maintain or achieve reduction. She was placed in a long leg splint that was well padded with Betadine dressing and stirrups. She tolerated the procedure well. Pain medicine and sedation was given by the emergency department consisting of Fentanyl and Versed.

ASSESSMENT:
This is a 57-year-old lady with a right open tibia and a right pilon fracture.

PLAN:
1. Irrigated and splinted in the emergency room. Betadine dressing applied.
2. Antibiotics written for.
3. Complete radiographic workup.
4. Would appreciate trauma input regarding multitrauma.
5. I have discussed this plan with emergency department.
6. I have discussed this plan with my chief, Dr. Jeremy Statton.
7. Operating room tonight if cleared or for operating room in the morning.

Electronically signed on 09/10/2007 4:54PM

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CONSULTATION

NAME OF PATIENT: ENGLAND, FANNY
MEDICAL RECORD NUMBER: 1153375

David Chen, M.D.

DC/jw
DD: 08/17/2007 @ 18:47
DT: 08/19/2007 @ 10:22
EDIT: 08/19/2007 @ 10:22
JOB #: 501843

530 South Jackson Street
Louisville, KY 40202
Telephone 502-562-3000

University Hospital
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UofL Health Care

EMERGENCY ROOM NOTE

NAME OF PATIENT: ENGLAND, FANNY 905
MEDICAL RECORD NUMBER: 1153375
ACCOUNT NUMBER: 36718179

DATE: 08/17/2007

ATTENDING PHYSICIAN: Melissa Platt, M.D. (present and available throughout the room 9 resuscitation)

HISTORY OF PRESENT ILLNESS: The patient is a 57-year-old Caucasian female who presents status post a one-car motor vehicle accident in which she was the restrained driver. She had no loss of consciousness. She had entrapment of her right lower extremity with a prolonged extrication time of greater than one hour. She presented complaining of pain to her right lower extremity and her back.

PAST MEDICAL HISTORY: Significant for hypertension and diabetes. She had an unknown back surgery prior.

ALLERGIES: She has no known drug allergies.

MEDICATIONS: She does not remember her medications. She takes medications for blood pressure and diabetes.

FAMILY HISTORY: No related family history.

SOCIAL HISTORY: Denies smoking, drinking or drug use. Last tetanus was unknown.

PHYSICAL EXAMINATION:

VITAL SIGNS: Her temperature was 98.7 degrees Fahrenheit, heart rate 105, respiratory rate 28, blood pressure 194/119 and oxygen saturations were 96% on 4 liters nasal cannula.

GENERAL: She was uncomfortable, well developed and well nourished with a Glasgow Coma Scale of 15.

EYES: Her pupils were 3 millimeters equal, round and reactive bilaterally.

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EMERGENCY ROOM NOTE

NAME OF PATIENT: ENGLAND, FANNY
MEDICAL RECORD NUMBER: 1153375

ENT: She had a left tympanic membrane perforation that she reported old, associated with deafness in that ear. She had no nasoseptal hematoma, no malocclusion.

NECK: In a cervical collar with no obvious injuries, no spinous process tenderness.

LUNGS: She has a normal respiratory effort. Her lungs are clear to auscultation bilaterally. She has tenderness to palpation over her right chest wall with ecchymosis of her right chest wall.

HEART: Tachycardic and regular with intact radial and pedal pulses.

ABDOMEN: Soft, non-tender and non-distended, normoactive bowel sounds. Has normal rectal tone and no gross blood. She

GU: She has normal female external genitalia.

EXTREMITIES: Her right lower extremity has an open tibia/fibula fracture. She moves her toes up and down.

BACK: No spinous stepoffs. No spinous tenderness to palpation.

PELVIS: Stable.

SKIN: She has ecchymosis to her right chest wall. She has an open tibia/fibula fracture of her right lower extremity and she has an abrasion to her left knee.

NEUROLOGICAL: Cranial nerves intact. Her sensory motor exam is otherwise intact. She was alert and oriented times three.

ROOM 9 INTERVENTIONS: The patient was brought to room 9 by ground Emergency Medical Services. She was connected to oxygen via nasal cannula and connected to cardiac, blood pressure and pulse oximetry monitor. Her airway was self maintained. Her breathing was spontaneously with equal breath sounds and chest rise bilaterally. Her circulation, sinus rhythm on all monitors, two peripheral IV's. She presented with a Glasgow Coma Scale of 15. She was transferred to room 9 bed in a cervical collar and a backboard. Prior to arrival, she received 100 milligrams of Fentanyl. In room 9, blood was drawn and laboratories were sent. X-rays were done including a chest, pelvis and right tibia/fibula. Chest x-ray showed increased pulmonary markings on the right versus the left, no fractures and no pneumoperitoneum. The pelvis x-ray showed no acute fractures. The tibia/fibula x-ray showed a right mid shaft tibia right fibular fracture and a

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EMERGENCY ROOM NOTE

NAME OF PATIENT: ENGLAND, FANNY
MEDICAL RECORD NUMBER: 1153375

right pilon. FAST scan performed by Dr. Herold was negative in all four quadrants. The patient was log rolled off the board. A Foley catheter was placed. The patient's history and plan will be discussed with family in their presence. Consult orthopedic surgery.

IMPRESSION:
1. Right tibia/fibula fracture, both open fractures.
2. right pilon fracture
3. Seat belt sign.

DISPOSITION: CAT scan for MAN scan of T and L recons and on to emergency department, bed #16 with disposition determined later.

CRITICAL CARE TIME: 15 minutes.

Addendum: The patient's right tibia/fibula fracture, orthopedic surgery was present in room 9 and the patient's open fracture was irrigated with approximately 2 liters of normal saline and splinted in a long posterior leg splint with stirrups. The patient received a tetanus. The patient was received Kefzol and tobramycin in room 9 for pain control, the patient received ____ 1 milligrams, Fentanyl 200 milligrams and she received Versed 2 milligrams for an attempted reduction of the right tibia/fibula by orthopedic surgery which was unsuccessful in room 9.

Electronically signed on 09/05/2007 12:09PM

Katherine Susanne Herold, M.D.

KSH/jw
DD: 08/17/2007 @ 18:50
DT: 08/19/2007 @ 11:09
EDIT: 08/19/2007 @ 11:09
JOB #: 501842

DMC
P.O. BOX 318
MASON, MI 48854

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [X] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 0005153900

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): ENGLAND, FANNIE

3. PATIENT'S BIRTH DATE MM DD YY: 11 13 1959 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 874 NEW ENGLAND RD

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: EDMONTON STATE: KY

8. PATIENT STATUS: Single [ ] Married [ ] Other [X]

CITY: STATE:

ZIP CODE: 42129 TELEPHONE (Include Area Code): ( )

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 08/17/2007

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY: 08 17 2007

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. 959.8 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 08 17 2007	08 17 2007	42	YES	A0431	SH	1	7,665.00	1		G2	161654220
										NPI	1992700173
2 08 17 2007	08 17 2007	42	YES	A0436	SH	1	8,944.00	86		G2	161654220
										NPI	1992700173
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 161654220 [X]

26. PATIENT'S ACCOUNT NO.: 07-6567

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 16,609.00

29. AMOUNT PAID: $ 0.00

30. BALANCE DUE: $ 16,609.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

EDWARD R MARASCO 11/26/2007

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

From: Scene of accident 3700.57N, 8533.32W EDMONTON, KY 42129

To: UNIVERSITY OF LOUISVILLE HOSPITAL MEDICAL CENTER 530 S JACKSON ST LOUISVILLE, KY 41512

a. b.

33. BILLING PROVIDER INFO & PH. # (800) 550-1605

CJ CRITICAL CARE/STATCARE

PO BOX 951881

CLEVELAND, OH 44193

a 1992700173 b G2 161654220

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

Patient Information				Details	
STATCARE Base: Glasgow Unit: SC2-A PRID: 2184001 Date/Time: 08/17/2007 16:26 Flight Number: : 07-3936 Patient: Fannie England				Chief Complaint:	47 y/o Female operator of standard size pickup truck that left the roadway and went into a field. Pt. was pinned inside the vehicle for approx. 1 hour. Fire and EMS crews on scene report the Pt. was conscious and complaining of Rt. leg and back pain.
Times:	**Dispatch:** 15:58 **EnRoute:** 16:10 **At Ref:** 16:24 **At Patient:** 16:26	**Lv Patient:** 16:32 **Lv Ref:** 16:35 **At Rec:** 17:15 **TxCare:** 17:17 **Available:** 19:01 **Max Alt:** 2500		HPI:	47 y/o Female who was involved in single vehicle accident near Edmonton, Ky. The pick up truck she was driving left the road way and went into a field. Pt. was pinned in the vehicle for approx. 60 minutes while Fire and EMS worked to free her. According to report she was conscious, and alert c/o pain in her back and Rt. leg that was pinned between the seat and the firewall. Pt. has Hx. of Htn and diabetes. She was removed from the vehicle fully immobilized and taken to the ambulance. Initial injuries deformity of the Rt. lower leg which appears to be an open Fx. minor laceration to the Lt. knee. Placed on nasal O2. Air ambulance requested for transport
Crew:	**Crew 1:** Gilreath **Crew 2:** *Middleton **Crew 3:** *Ford ** ALS Provider*			Scene Description:	Full size pick truck that left the roadway crashed through fence and came to rest in field.
Referring:	Barren-Metcalfe County Ems 703 E Main St Glasgow, KY 42129 (270) 651-1175			Destination Basis:	*None given.*
Location:	Edmonton, Ky. Zip Code: 42129			Last NPP Given:	None
Receiving:	University of Louisville Hospital Medical Center Emergency Department 530 S Jackson St Lousiville, ky 40202 Rec MD: 144			Given This Trip?:	No
Patient:	England, Fannie 874 New England Rd Edmonton, KY 42129 Sex: F DOB: 11/13/1959 Tx Age: 47y Subscriber: No			Consent Signed?:	No
Pt Category:	Trauma, Adult			CMN Obtained?:	No
Outcome:	Treated, Transported				
Insurance None Given					
Odometer Start: At Rec: **Mileage** Loaded: 86		At Ref: End: Total: OOC:			

Procedure	Details	Medicare Code
RW Ambulance Service	**Medications:** - Fentanyl - Promethazine	A0431
RW Mileage	86 miles	
Oxygen		A0422

PRID: 2184001 **Flight Number:** :07-3936

Service: STATCARE
Base: Glasgow
Unit: SC2-A
Tail/Reg: N136KY
Dispatched As: Trauma, Adult
Ref Type: Scene Unscheduled
Scene Grid: N3700.57 W8533.3
Response Code: 3
Ref Name: Barren-Metcalfe County Ems
Location: Edmonton, Ky.
Ref. Zip: 42129
Ref County: Metcalfe
Moved Via: Stretcher
Position: Supine
Receiving: University of Louisville Hospital Medical Center (Emergency Department)
Rec. MD: 144
Rec. RN: Wiggles
Outcome: Treated, Transported

Date: August 17, 2007
Flight Plan: VFR
Team: Critical Care
Driver: Gilreath, Steven
Primary Caregiver: *Middleton, Walter
Secondary Caregiver: *Ford, Beverly - EMT-P
** ALS Provider*

Last Name: England **First:** Fannie
Address: 874 New England Rd
City: Edmonton **ST:** KY **Zip:** 42129
County: Metcalfe **Citizenship:** United States
DOB: 11/13/1959
Age: 47y **Sex:** F **Weight:** 86.3 kg
Subscriber: No
Race: White, non-Hispanic
Barriers to Care: None
Billing Information:
None Given

Odometer
Ld Miles: 86

Times
Received: 15:57
Dispatch: 15:58
EnRoute: 16:10
At Ref: 16:24
At Patient: 16:26
Lv Patient: 16:32
Lv Ref: 16:35
At Rec: 17:15
TxCare: 17:17
Available: 19:01
Max Alt: 2500

Notice of Privacy Practices Given: None
Consent Signed: No
Medical Necessity Signed: No

Scene Information

Description: Full size pick truck that left the roadway crashed through fence and came to rest in field.
Air Modifier: Air-C-Time Precludes Ground Transport

Chief Complaint (Category: Trauma, Adult)

47 y/o Female operator of standard size pickup truck that left the roadway and went into a field. Pt. was pinned inside the vehicle for approx. 1 hour. Fire and EMS crews on scene report the Pt. was conscious and complaining of Rt. leg and back pain.
Duration: 90 Minutes

History of Present Illness

47 y/o Female who was involved in single vehicle accident near Edmonton, Ky. The pick up truck she was driving left the road way and went into a field. Pt. was pinned in the vehicle for approx. 60 minutes while Fire and EMS worked to free her. According to report she was conscious, and alert c/o pain in her back and Rt. leg that was pinned between the seat and the firewall. Pt. has Hx. of Htn and diabetes. She was removed from the vehicle fully immobilized and taken to the ambulance. Initial injuries deformity of the Rt. lower leg which appears to be an open Fx. minor laceration to the Lt. knee. Placed on nasal O2. Air ambulance requested for transport

Past Medical History	Current Medications	Allergies
Diabetes Hypertension Obtained From: Patient	Unknown	None - Reported By Patient

Neurological Exam	Glasgow Coma Scale
Level of Consciousness: Alert **Loss of Consciousness:** No **Orientation:** Oriented **Chemically Paralyzed:** No	E M V Tot Int: 4 6 5 = 15

Pupils	Left	Right
Size:	Normal	Normal
React:	Reactive	Reactive

	Motor	Sensory
LA:	Normal	Normal
RA:	Normal	Normal
LL:	Normal	Normal
RL:	Normal	Normal

Neuro Exam Alert

Sensory Comments: Responsive to all stimuli

Revised Trauma Score

7.84

Airway	Respiratory
Status: Patent	**Effort:** Normal **Sounds:** **L:** Clear **R:** Clear **Oxygen:** 15 lpm via NRB

Cardiovascular

JVD: Not Appreciated **Cap. Refill:** Less than 2 Seconds

Edema: Not Appreciated

Pulses	Left	Right
Carotid:	Not Checked	Not Checked
Radial:	Strong	Strong
Femoral:	Not Checked	Not Checked
Dorsalis:	Strong	Weak

Initial Physical Findings

Assessment

Neck Findings: C-collar in place; Pt has no complaints

Head: Normal **Findings:** No trauma / complaints noted

Chest: Normal, Normal BS

Left Upper Abdomen: Normal

Right Upper Abdomen: Normal

Left Lower Abdomen: Normal

Right Lower Abdomen: Normal

Abdominal Comments: Neg N/V; no complaints

Abdominal Appearance: Slightly obese, no trauma noted

Abdominal Palpation: Soft with no distention, tenderness or guarding

Pelvis: Normal **Findings:** Pt had no complaints upon exam

Skin: Normal, Warm

Left Arm: Normal

Right Arm: Normal

Left Leg: Normal

Right Leg: Abnormal Pulse, Tenderness, Weakness

Extremity Findings: Mult. small lac's to R knee, no other trauma to R. Compound fx to L lower leg with slight/moderate bleeding; splint and dsg are in place with weak pulse noted

Spine: Not Done

Back Findings: Pt immobilized on full board prior to arrival; Pt c/o slight lower back pain

Immobilization: Collar:PTA, CID:PTA, LBB:PTA, KED:N/A, MAST:N/A

Labs

Date	Time	Glu
8/17/07	00:00	117

Fluids Before & During Transport	IVs Prior to Assessment

INTAKE		OUTPUT	
	Before During		Before During
CRYS:	800 200	EBL:	0 0
COLL:		UO:	
OTHER:		OTHER:	

IV#	Gauge	Site	Solution	Rate	Performed By	Outcome
1	18	L forearm	LR	150	EMS Provider	Unchanged
2	18	R AC	LR	150	EMS Provider	Unchanged

Medications / Infusions Prior to Assessment

No Medications / Infusions Prior to Assessment

Activity

TIME	H.R.	B.P.	MAP	SaO2	RESP	Effort	RHYTHM	GCS	Pain	ACTION	Comments	*
16:24											Statcare arrive on the scene of single vehicle accident in Edmonton Co. EMS and Fire on scene. Pt. has been extricated and placed in the ambulance.	
16:26	85	164/91	115	100	24	Labored	Normal Sinus Rhythm	4/6/5	10		Found 47 y/o Female in ambulance, received report from EMT-P. Pt. is awake, alert, oriented X 3. Primary Survey: Airway Patent, Breathing spontaneous unlabored, Circulation + pulses all four Ext's, Disability moves upper Ext's with purpose, Rt. lower Ext. is injuried and secured with splint. Lt. lower is moved with purpose.	CRW2
16:29	85	164/91	115	100	24	Labored	Normal Sinus Rhythm	4/6/5	10		Rapid trauma assessment: Head normocephalic, perla, ears, nose, and mouth clear. There are no battle signs. Head is not secured. Head immediately bolcked and secured to LSB. Neck is secured with c-collar, no c/o neck pain. chest no visible trauma or complaint, bilat = expansion, clear bilat. Abd has no visible trauma, soft, nontender, pelvis is stable, gu without complaint. Ext. Rt. and Lt. upper are without injury. Rt. lower secured in splint + open Fx. Tib., Fib., bleeding controlled, Pt. c/o severe pain whenever leg is touched or moved. cannot move toes. Abrasion / laceration to Lt. knee bleeding controlled.	CRW2
16:32	85	164/91	115	100	24	Labored	Normal Sinus Rhythm	4/6/5	10		Pt. moved to flight stretcher, taken to helicopter and loaded without difficulity, secured to air frame.	CRW2
16:39	91	166/118	134	100	26	Normal	Normal Sinus Rhythm	4/6/5	10		Pt. placed on O2 15 lt/min NRM, placed on Propaq monitor. She is in severe pain crying.	CRW2
16:40	91	166/118	134	100	26	Normal	Normal Sinus Rhythm	4/6/5	10	Medication:	Fentanyl, 100 MCG via IV - Push given by Walter Middleton. Authorization: Via Protocol. Pt. Response: Improved.	CRW2
16:50	108	205/129	154	100	24	Normal	Sinus Tachycardia	4/6/5	8		Some relief of pain noted	CRW2
16:56	93	131/92	105	100	20	Normal	Normal Sinus Rhythm	4/6/5	8		No change in patient status.	CRW2
17:00	93	161/83	109	100	20	Normal	Normal Sinus Rhythm	4/6/5	9		Pain starting to increase again possibly due to virbration.	CRW2
17:06	87	130/77	95	100	20	Normal	Normal Sinus Rhythm	4/6/5	10	Medication:	Pain increasing, crying, given fentanyl IV.Fentanyl, 100 MCG via IV - Push given by Walter Middleton. Authorization: Via Protocol. Pt. Response: Improved.	CRW2
17:07										Hosp. Notify:	Trauma alert sent by Beverly Ford via Radio. Phy. 144 report called to:	CRW2
17:10	84	164/91	115	100	20	Normal	Normal Sinus Rhythm	4/6/5	8	Medication:	Nausea reported, medication given.Promethazine, 12.5 MG via IV - Push given by Walter Middleton. Authorization: Via Protocol. Pt. Response: Improved.	CRW2
17:15	162	164/90	115	100	18	Normal	Normal Sinus	4/6/5	7		Landing assured ULH Helipad. Pt.	CRW2

								Rhythm				to Room #9, report given	

** Assessment made by*

Patient Belongings: clothes, shoes
Dispatch Factors: None

Middleton, Walter: *Electronically Signed on 08/17/2007 21:51:37 EST*

Ford, Beverly: *Electronically Signed on 08/17/2007 19:43:29 EST*

Medical Director: _____

Utilization Review

STATCARE
Bowman Field
2807 Taylorsville Road
Louisville, KY 40205-3166
(502) 479-9111

Date: 08-17-07 **Patient:** England, Fannie **Age:** 47 y **Type:** Scene
Flight Number: : 07-3936 **Unit:** SC2-A **Mode:** Rotor Wing
Referring: Barren-Metcalfe County Ems Edmonton, Ky.
Receiving: Emergency Department University of Louisville Hospital Medical Center 530 S Jackson St Lousiville, ky 40202

Reason for Transfer

- Scene Run

Specialty Service needed: Trauma Service

Medical Information

Chief Complaint: 47 y/o Female operator of standard size pickup truck that left the roadway and went into a field. Pt. was pinned inside the vehicle for approx. 1 hour. Fire and EMS crews on scene report the Pt. was conscious and complaining of Rt. leg and back pain.

History of Illness: 47 y/o Female who was involved in single vehicle accident near Edmonton, Ky. The pick up truck she was driving left the road way and went into a field. Pt. was pinned in the vehicle for approx. 60 minutes while Fire and EMS worked to free her. According to report she was conscious, and alert c/o pain in her back and Rt. leg that was pinned between the seat and the firewall. Pt. has Hx. of Htn and diabetes. She was removed from the vehicle fully immobilized and taken to the ambulance. Initial injuries deformity of the Rt. lower leg which appears to be an open Fx. minor laceration to the Lt. knee. Placed on nasal O2. Air ambulance requested for transport

Comments:

Receiving Hospital Selection

- Patient admitted to receiving hospital

Level of Care

Acutely deteriorating clinical condition

- Ongoing blood loss

Comments: *Compound fx L lower leg with blood loss and dec circulation*

Mode of Transport - Air Transports

- Patient's Clinical Condition requires urgent initiation of treatment and diagnostics. The delay associated with ground transport will be detrimental to the patient

STATCARE
Louisville Medical Center

Transport Summary

This document contains protected health information

Date of Service: 2007-08-17
Request Number: 0018-A
Run Number: 07-3936
Team: STATCARE
Call Type: Scene
Rotor Wing
Trauma

Call Started: 8/17/2007 at 15:57
Taken By: Price, Richard

Patient Name: ENGLAND, FANNIE
Address:
,
Sex: Female
DOB: 1960-08-17

Primary Complaint: Motor Vehicle Accident
Complaint #2:
Complaint #3:
Complaint #4:
Complaint #5:
Other Complaint:

Primary Payor:

Dispatch Comments: MVA, GC/508

Dispatched By: Price, Richard

Vehicle: SC2-A
Responded From: Glasgow Municipal Airport

Pilot: GILREATH, STEVEN
Nurse: MIDDLETON, WALT
Paramedic: FORD, BEVERLY
Other:

Notified Pilot:
Weather Confirmed:
Dispatched: 15:58
En Route: 16:10
At Scene: 16:24
Transporting: 16:35
At Destination: 17:15
Depart 3:
Arrive 4:
Partially Available: 17:48
Available: 19:01

Loaded Statute Miles: 86

Requesting Agency/Facility:
BARREN-METCALFE COUNTY EMS
703 E MAIN ST.

GLASGOW, KY 42141

Caller: Julie
Phone: (270) 651-1175 Ext.
Referring Physician:

Pick Up Information:
Scene Response
N3700.57 W8533.32

EDMONTON, KY 42129

Initial Priority: Emergency - R W

Phone: (502) 000-0000 Ext.

Drop Off Information:
UNIVERSITY OF LOUISVILLE HOSPITAL
530 S JACKSON ST
38°14.85'N 085°44.60'W
LOUISVILLE, KY 40202

Transport Priority: Emergency - R W
Receiving Physician:
Phone: (502) 562-3015 Ext.

Notes for run number 07-3936

Narrative / Medical Necessity Form

No attachments

Enter another run number

CJ Critical Care Transportation Systems

STATCARE

ASSIGNMENT OF BENEFITS AUTHORIZATION, RESPONSIBILITY FOR PAYMENT AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that I am financially responsible for the services provided to me by STATCARE regardless of insurance coverage. I request that payment of authorized Medicare or other insurance benefits be made on my behalf to STATCARE for any services provided to me now or in the future by STATCARE. I agree to immediately remit to STATCARE any payments that I receive directly from any source for the services provided to me and I assign all rights to such payments to STATCARE.

Remittance Address:
CJ Critical Care/STATCARE
PO Box 951881
Cleveland, OH 44193

I authorize all contracted services with STATCARE to disclose all or any part of the patient medical record including, but not limited to, the Social Security Administration, Centers for Medicare and Medicaid Services, their Intermediaries or Carriers, Worker's Compensation Carriers, employers, Medical Assistance Carrier and/or any other health or auto insurance agency, now or in the future for any services provided to me by STATCARE.

All billing questions or concerns should be directed to CJ Critical Care billing office at 1-800-660-1605.

I also acknowledge that I have received a copy of the STATCARE Notice of Privacy Practices. A copy of this form is as valid as the original.

EZZ5578/ENGLAND ,FANNIE
1153375 01/01/1950 57 F
36718179 08/17/07

PATIENT SIGNATURE _____ DATE 8/17/2007

PATIENT REPRESENTATIVE'S SIGNATURE _____ RELATIONSHIP TO PATIENT _____

Please sign this form and mail it to the remittance address listed above. Thank you for your cooperation and we look forward to assisting you by billing your insurance for this medical transport.

Patient unable to sign because: Fully immobilized, Medication

Walter Middleton RN _____ Walter Middleton RN 07-3936 8/17/2007
CREW PRINTED NAME CREW SIGNATURE FLIGHT # DATE